Medical History
Confidential

Name:____ Date_________
Address:__________________________________State________Zip_________
City:_______________Phone________________ Gender______DOB__/__/__
Medical doctor______________________Date of last visit_____Reason____________
Have you ever had acupuncture/Chinese herbs________
Name of Acupuncturist______________ Date of last visit_________ Reason_________
Emergency contact: Name__________________________ Phone__________________
____

Please comment on the following categories:
Major complaint for treatment today:____
____
____

Possible reason for condition:____
____
____

What makes it better and worse?____
____
____

What treatments have you tried for this condition and did they help?_________________
____
____
____
____

Current medications you are taking and what they are for:_________________________
____
____
____

Current nutritional/herbal supplements you take:________________________________
____

Family history:
Father: Living?_______Age________ If deceased cause of death-
____

Mother: Living?_______Age________ If deceased cause of death-
____

Other Parent: Living?_______Age________ If deceased cause of death-______________
Spouse: Living?_______Age________ If deceased cause of death-
____

Siblings: Living?_______Age________ If deceased cause of death-_________________
____
____

Children: Gender “s”______________________________ Health status-____________
____

Major illnesses of blood relatives (i.e., high blood pressure, addiction, diabetes, mental illness, stroke etc.):____
____
____
____

How would you describe you health as a child____________________________________

Major illnesses/injuries/surgeries in your past:___________________________________

Current illnesses or infectious diseases:____

Immunizations received:____

Digestive health issues:____

Blood sugar issues:____

Allergies:____

Reproductive health issues:____

Urinary tract issues:____

Cardiovascular health:____

Most recent medical tests:____

Anything else you'd like to share about your situation:___________________________

Please attach copies of any recent and pertinent medical diagnostic test information:

I authorize treatment of oriental medical techniques from Brenyn Schultz-Williams. All the information on this form is correct. I understand I am responsible for payment of all fees to the acupuncturist on the day that services are scheduled or rendered unless other arrangements are made in advance. I agree to pay full price for missed appointments that are not canceled 24 hours in advance or there has been an emergency.

Patient signature:____Date________

Consent to treat a minor/child: I herby authorize treatment to my child/minor,

Name:__________________________________

Parent/Legal guardian Signature:_______________________________Date________

MANDATORY DISCLOSURE/ INFORMED CONSENT

Living Creative Wellness:
Acupuncture and Oriental Medicine
Brenyn Schultz-Williams
DIPL.O.M, L.Ac., CMT

Education and Experience:

Brenyn Schultz-Williams earned his Masters of Science in Oriental Medicine from Southwest Acupuncture College in 2009. This 3000-hour program focused training on, acupuncture, traditional oriental herbal medicine, physical therapy, nutrition, injection therapy exercise and breathing therapies. Diplomat in Acupuncture and Oriental medicine in December 2009. Brenyn is certified in clean needle technique, injection therapy and has been a practicing massage therapist since 2002. Brenyn is an American Association of Acupuncture and Oriental Medicine member and is a licensed Acupuncturist and Massage therapist in the state of Colorado. None of his licenses, certifications or registrations have been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule: Payment to Living Creative Wellness is due on the day services are scheduled or rendered unless other arrangements are made. Cost for treatments are negotiable.

Patient's Rights

-The patient is entitled to receive information about the methods of therapy, techniques used and duration of therapy if known.

-The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time

-In a professional relationship, sexual intimacy is never appropriate and should be directed to the director of the Division of Registrations within the Department of Regulatory Agencies.

Acupuncture is regulated by the Director of Registrations within the Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800.

Informed Consent:

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named, including those working at this or any other office, whether signatories to this form or not. Methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy, Tui-Na/massage, Chinese or western herbal medicine, aromatherapy and nutritional/wellness counseling.. Oriental medicine and Acupuncture is a safe method of treatment, but it may have side effects, including bruising, nausea, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Burns and/or scarring are a potential risk of moxibustion. I understand that other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Oriental medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I understand I am responsible for payment of all fees to the acupuncturist on the day that services are scheduled or rendered unless other arrangements are made in advance. I agree to pay full price for missed appointments that are not canceled 24 hours in advance unless an emergency has occurred. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understand this document.

____

Patient's or Guardian's Signature   Date